

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REC'D FEB 21 1939

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

1779  
Do not use this space.

1. PLACE OF DEATH <sup>3</sup>

(a) County Callaway Registration District No. 104

(b) Township Fullon Primary Registration District No. 3.028 Registered No. 1

(c) City Fullon (d) Street No. State Hospital #1 St. \_\_\_\_\_

(e) Length of residence in city or town where death occurred yrs. 6 mos. 18 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 162 Frank Spurgeon

(a) Residence, No. Route 2 Canton Mo. St.  (If nonresident, give city or town and State)

(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mrs. Frank Spurgeon

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 30th 1885

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.

53 53 6 2 \_\_\_\_\_

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. \_\_\_\_\_

9. Industry or business in which work was done, as saw mill, bank, etc. Farmer

10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation 20

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Lewis Co. Mo.

FATHER 13. NAME J. H. Spurgeon

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St Louis Mo.

MOTHER 15. MAIDEN NAME Johanna Baum

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Warsaw Ill.

17. INFORMANT (ADDRESS) State Hospital #1

18. BURIAL, CREMATION, OR REMOVAL PLACE Wardance DATE Jan 3 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) W. S. Kelly

20. FILED Jan 1st 1939 R. N. Crews Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 1st 1939

22. I HEREBY CERTIFY, that I attended deceased from July 2nd 1938 to Jan 1st 1939

I last saw him alive on 11/1 1938. Death is said to have occurred on the date stated above, at 10:47 a.m.

The principal cause of death and related causes of importances were as follows:

Lobar Pneumonia left.

Other contributory causes of importances: Exhaustion; Dehydration; Chorea; Empyema on right.

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? Autopsy Was there an autopsy? Yes.

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? No.

If so, specify \_\_\_\_\_

(Signed) Geo. F. Wood, M. D.

(Address) State Hospital #1 Fullon Mo.

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by

*M. S. Kelly*, Registered Apprentice No. *1954*  
working under my personal supervision.

Signed

*M. S. Kelly*

Licensed Embalmer No.

*1958*

P. O. Address

*Center MA*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**